Supreme Court, U.S.
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No. 00-1295

In The

Supreme Court of the United States

COMMUNITY HEALTH PARTNERS, INC., and RESERVOIR PARK HEALTH SERVICES, INC., doing business as Center Care,

Petitioners,

v.

COMMONWEALTH OF KENTUCKY and JANIE A. MILLER, Commissioner of Insurance,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

The Sixth Circuit Court of Appeals held that Kentucky's Any Willing Provider ("AWP") statute, Ky. Rev. Stat. Ann. § 304.17A-270, "regulates insurance" and, therefore, is saved from preemption by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

Respondent disagrees with the question presented to this Court by Petitioners. Therefore, Respondent offers the following question for this Court's consideration.

The Question Presented is:

Whether Kentucky's Any Willing Provider statute, Ky Rev. Stat. Ann. § 304.17A-270, is a statute that "regulates insurance" and, therefore, is saved from ERISA preemption?

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF CONTENTS ii

TABLE OF AUTHORITIES iii

STATEMENT OF THE CASE 1

REASONS FOR DENYING THE WRIT 4

I. The Sixth Circuit Properly Followed All Applicable Precedents Of This Court 5

a. The "Common Sense" Test 6

b. The Three McCarran-Ferguson Criteria ... 10

i. Kentucky's AWP Statute Transfers Or Spreads Policyholders' Risk 14

ii. Kentucky's AWP Statute Meets The Criteria Of Affecting An Integral Part Of The Relationship Between The Insurer And The Insured 16

iii. Kentucky's AWP Statute Meets The Test Of Limiting Regulation To Entities Within The Insurance Industry .. 17

II. The Sixth Circuit's Decision Is Not In Conflict With Any Other Circuit 18

a. The Eighth Circuit 18

b. The Fifth Circuit 19

III. Petitioners' Attempt To Treat All State AWP Statutes The Same Must Fail 23

CONCLUSION 25

TABLE OF AUTHORITIES

Page

CASES

American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc., 973 F. Supp. 60 (D. Mass. 1997) ... 12, 15, 16

Blue Cross and Blue Shield of Alabama v. Nielsen, 917 F. Supp. 1532 (N.D. Ala. 1996), *vacated as moot*, 142 F.3d 1375 (11th Cir. 1998) 22

California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc., 519 U.S. 316 (1997) 24

Cigna Healthplan of Louisiana v. Louisiana, 82 F.3d 642 (5th Cir. 1996), *cert. denied*, 519 U.S. 964 (1996) 19, 21, 22

Corporate Health Ins., Inc. v. Texas Department of Insurance, 215 F.3d 526 (5th Cir. 2000), *pet. for cert. pending sub nom. Montemayor v. Corporate Health Insurance* (No. 00-665) 22

DeBuono v. N.Y.S.A. – ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997) 24

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 6

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) 10, 11, 12, 13, 21

John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank, 510 U.S. 86 (1993) 6

Kentucky Ass'n of Health Plans v. Nichols, 227 F.3d 352 (6th Cir. 2000) 3

Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985) 3, 5, 6, 9, 22, 23

National Business Ass'n v. Morgan, 770 F. Supp. 1169 (W.D. Ky. 1991) 9

TABLE OF AUTHORITIES – Continued

Page

New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995) 24

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) 9

Prudential Insurance Co. of America v. National Park Medical Center, 154 F.3d 812 (8th Cir. 1998) 18

Stuart Circle Hospital Corp. v. Aetna Health Management, 995 F.2d 500 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993) 11, 12, 14, 15, 16

Texas Pharmacy Association v. Prudential Insurance Co. of America, 105 F.3d 1035 (5th Cir. 1997) 11, 12, 19, 20

Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119 (1982) 10, 13

United States Department of the Treasury v. Fabe, 508 U.S. 491 (1993) 13

UNUM Life Insurance Co. v. Ward, 526 U.S. 358 (1999) 4, 5, 6, 10, 22, 23

Washington Physicians Service Association v. Gregoire, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999) 19

STATUTES AND REGULATIONS

15 U.S.C. § 1012(b) 5

29 U.S.C. § 1144(b)(2)(A) 1, 5

Ark. Code Ann. § 23-99-204(a)(3) 18

Ky. Rev. Stat. Ann. § 304.14-135 8

TABLE OF AUTHORITIES – Continued

Page

Ky. Rev. Stat. Ann. § 304.17A-110(3) (Banks-Baldwin 1995) 1

Ky. Rev. Stat. Ann. § 304.17A-005(18) 3

Ky. Rev. Stat. Ann. § 304.17A-005(23) 2

Ky. Rev. Stat. Ann. § 304.17A-270 .....1, 2, 3, 17

Ky. Rev. Stat. Ann. § 304.17A-300 9

Ky. Rev. Stat. Ann. § 304.17A-505(1)(h) 8

Ky. Rev. Stat. Ann. § 304.17A-505(1)(k) 8

Ky. Rev. Stat. Ann. § 304.17A-515(1)(e) 8

Ky. Rev. Stat. Ann. § 304.17A-520 9

Ky. Rev. Stat. Ann. § 304.17A-525(3) 8

Ky. Rev. Stat. Ann. § 304.17A-527 8

Ky. Rev. Stat. Ann. § 304.17A-545 9

Ky. Rev. Stat. Ann. § 304.17A-700 *et seq* 8

Ky. Rev. Stat. Ann. § 304.38-060 9

Ky. Rev. Stat. Ann. § 304.38-060(2)(d) 8

806 KAR 17:300 8

806 KAR 38:030 8

STATEMENT OF THE CASE

The Sixth Circuit Court of Appeals, affirming the United States District Court for the Western District of Kentucky, ruled that Kentucky's Any Willing Provider ("AWP") statute, Ky. Rev. Stat. Ann. § 304.17A-270 (formerly § 304.17A-110(3)) is not preempted by ERISA. While both courts found that Kentucky's AWP statute does "relate to" and is "connected with" ERISA plans, the courts further found that Kentucky's AWP statute fell within the savings clause, see 29 U.S.C. § 1144 (b)(2)(A), as being a state law that regulates insurance.[1] Petitioners' Appendix 1a-3a.

In 1994, in an effort to reform Kentucky's healthcare market, the Kentucky General Assembly passed House Bill ("HB") 250. Kentucky's AWP statute was included in that bill and later codified in Ky. Rev. Stat. Ann. § 304.17A-110(3). Ky. Rev. Stat. Ann. § 304.17A-110 included other important patient protection regulatory provisions such as guaranteed renewability for eligible individuals and a pre-existing condition exclusion provision. Respondent's Appendix A.

To further regulate the business of insurance, the General Assembly amended the Kentucky insurance code effective July 15, 1996 and April 10, 1998. Some of the patient protection provisions in Ky. Rev. Stat. Ann. § 304.17A-110 were amended and codified in other parts

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[1] Although the Department disagrees with the Sixth Circuit's conclusion that Ky. Rev. Stat. Ann. § 304.17A-270 "relates to" and is "connected with" ERISA plans, this response will only address the arguments raised in the Petition for a Writ of Certiorari.

of the insurance code. Kentucky's current AWP statute, which is at issue in this case, is found at Ky. Rev. Stat. Ann. § 304.17A-270. Petitioners' Appendix 103a. In drafting the AWP statute, the Kentucky General Assembly's clear focus was to regulate insurance and to provide an additional benefit to the consumers in Kentucky, many of whom were limited to one choice of insurer in their county or geographic area.

The language in Kentucky's AWP statute is simple. It provides that a "health insurer" may not "discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer." Ky. Rev. Stat. Ann. § 304.17A-270. *See also* Petitioners' Appendix 103a. "Insurer" is defined in subtitle 17A[2] as "any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky." Ky. Rev. Stat. Ann. § 304.17A-005(23). *See also* Petitioners' Appendix 104a-105a.

"Health benefit plan" is also defined in subtitle 17A as "any hospital or medical expense policy . . . nonprofit hospital, medical-surgical, and health service corporation

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[2] Subtitle 17A governs all "health benefit plans" issued in Kentucky.

contract . . . provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract . . . " Ky. Rev. Stat. Ann. § 304.17A-005(18). *See also* Petitioners' Appendix 103a-104a.

Petitioners, Community Health Partners, Inc. and Reservoir Park Health Services, Inc., d/b/a Center Care, challenged the Kentucky Department of Insurance's enforcement of Ky. Rev. Stat. Ann. § 304.17A-270 in the United States District Court for the Western District of Kentucky. It is important to note that the Kentucky Department of Insurance does not regulate Petitioners as they are merely administrators of provider networks and not insurers. Additionally, because Petitioners are not "health insurers," they are not one of the entities required to comply with Kentucky's AWP statute.

Petitioners asked the District Court to find the AWP statute unconstitutional and enjoin the Department from enforcing it against any party. On cross-motions for summary judgment, the District Court held that the statute is saved from ERISA preemption. Petitioners filed an appeal with the Sixth Circuit Court of Appeals.

Looking solely at the language in Kentucky's AWP statute and applying this Court's two-part test, the Sixth Circuit determined that Kentucky's statute regulates insurance.[3] *See Metropolitan Life Ins. Co. v. Massachusetts,*

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[3] The Court incorporated the majority and dissenting opinions in *Kentucky Ass'n of Health Plans v. Nichols*, 227 F.3d 352 (6th Cir. 2000), a case arising out of the United States District

471 U.S. 724 (1985); *UNUM Life Ins. of America v. Ward*, 526 U.S. 358 (1999).

In requesting Certiorari, Petitioners are asking this Court to find that the general concept behind an AWP statute prevents it from being a statute that regulates the "business of insurance." However, to reach this conclusion would require the Court to treat all state AWP statutes the same. That is not the Sixth Circuit's holding in this case. The Sixth Circuit correctly applied the two-part test to the specific language in Kentucky's insurance code and properly found that Kentucky's AWP law was saved from ERISA preemption. Therefore, Certiorari is not appropriate in this case.

REASONS FOR DENYING THE WRIT

Petitioners have failed to demonstrate any compelling reason to justify granting the Petition for a Writ of Certiorari. This case does not satisfy any of the criteria for the United States Supreme Court to grant review. The Sixth Circuit's decision is not in direct conflict with any precedents set by this Court and is not in direct conflict with any other Circuit Court's holding on this matter.

Court for the Eastern District, and, therefore, this response will reference that opinion, found at Petitioners' Appendix 31a-93a, and not the opinion found at Petitioners' Appendix 1a-3a.

I. The Sixth Circuit Properly Followed All Applicable Precedents Of This Court.

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); see also, *e.g.*, *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999) (same; quoting *Metropolitan Life*), this Court developed the test for determining whether a statute is saved from ERISA preemption because it "regulates insurance" within the meaning of 29 U.S.C. § 1144(b)(2)(A).

First, according to the mandate in *Metropolitan Life*, a court must inquire as to whether the statute regulates insurance as a matter of "common sense." The Sixth Circuit properly applied this part of the test to Kentucky's AWP statute and found that, as a matter of "common sense," Kentucky's AWP statute does regulate insurance. Petitioners' Appendix 52a-60a.

Second, *Metropolitan Life* requires a court to apply the three criteria developed under the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) to determine whether a practice constitutes the "business of insurance." The three criteria are as follows: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Metropolitan Life*, 471 U.S. at 743 (emphasis in original).

The Sixth Circuit properly applied the three criteria developed under the McCarran-Ferguson Act to the language in Kentucky's AWP statute and found that requiring all "insurers" offering "health benefit plans," in

Kentucky, to take all willing providers, willing to meet its terms and conditions, constituted the business of insurance. Petitioners' Appendix 60a-68a.

a. The "Common Sense" Test.

The Sixth Circuit's determination that Kentucky's AWP statute regulates insurance "as a matter of common sense," Petitioners' Appendix 52a-60a, is in compliance with this Court's precedents on the matter. Petitioners argue that AWP statutes regulate only the relationship between insurers and third parties.[4] Respondent disagrees.

First, unlike what Petitioners would have this Court believe, not all AWP statutes are the same. A court, being asked to determine if a state statute is preempted by ERISA, must look to the specific statutory language that is challenged. Then, the court must determine whether there is ERISA preemption.

The Sixth Circuit looked solely at the language in Kentucky's AWP statute when it determined that the statute regulates insurance. The Sixth Circuit concluded that the statute is "specifically directed toward 'insurers' and the insurance industry and [is one] that from a 'common sense view' regulate[s] insurance." Petitioners'

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[4] In support of their position, Petitioners cite to *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. at 373; *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740 (1985); and *John Hancock Mut. Life Insurance Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993).

Appendix 56a. Additionally, the Sixth Circuit, using the common sense view, determined that Kentucky's AWP statute regulates the business of insurance because the statute is located within the insurance code and specifically in subtitle 17A, which governs health benefit plans and the requirements of insurers offering those plans. The mere "fact that the Kentucky statute reaches self-insurers who are not protected by ERISA's deemer clause," did not alter the Sixth Circuit's view of Kentucky's AWP statute "as a statute regulating entities engaged in the business of health insurance." Petitioners' Appendix 56a.

Second, the Kentucky General Assembly passed the Kentucky Healthcare Reform Act ("HB 250") to further regulate the insurance market. The goal of HB 250 was to address issues of accessibility and portability. As with other patient protection provisions, Kentucky's AWP statute enriched the benefit to consumers contracting with health insurers. Prior to 1994, consumers were concerned about access to healthcare, especially in rural areas of the state. Kentucky's AWP statute was intended to address these concerns. As the Sixth Circuit concluded, Kentucky's AWP statute "increase[s] benefits to the insureds by giving them greater freedom to choose health care providers under the plans; and [it is] aimed at regulating this insurance relationship." Petitioners' Appendix 60a.

Insureds access their benefits through the health insurance contract and the certificates of coverage issued pursuant to the contract. Contained within all health insurance certificates of coverage are "plan delivery rules." Within the limitations set forth by state regulation, the insurer sets the rules. Those rules contain the "how,

when, where, and why" of accessing providers by the insured. Insurers contract with providers for the benefit of their insureds. The Department of Insurance, as the state agency charged with regulating insurance companies doing business in the Commonwealth, regulates many aspects of the insurer-provider relationship for the benefit of the consumer.[5] Common sense suggests that

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[5] The Department of Insurance requires managed care plans to demonstrate that "[a] provider network [is] . . . available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence, to the extent those services are available." Ky. Rev. Stat. Ann. § 304.17A-515(1)(e). Insurers are required to file all provider agreements with the Department. Ky. Rev. Stat. Ann. § 304.17A-527 and 806 KAR 17:300. Health Maintenance Organizations ("HMO") must file their provider directories with the Department and update them as necessary. 806 KAR 38:030. Managed care plans are required to notify an enrollee if his or her primary care provider has been terminated from the plan. Ky Rev. Stat. Ann. § 304.17A-525(3). When deciding whether to issue a certificate of authority to an HMO, the Commissioner may consider a HMO's provider agreements by provider type. Ky. Rev. Stat. Ann. § 304.38-060(2)(d). The Department regulates an insurer's responsibility to promptly pay a clean claim to a provider. Ky. Rev. Stat. Ann. § 304.17A-700 *et seq*. The Department regulates the type of claim forms that insurers can require providers to use. Ky. Rev. Stat. Ann. § 304.14-135. As part of an insurer's responsibility to disclose the terms and conditions of a health benefit plan, the insurer must have "[m]easures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider." Ky. Rev. Stat. Ann. § 304.17A-505(1)(h). Additionally, an insurer must inform an insured or an enrollee "that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer." Ky. Rev. Stat. Ann. § 304.17A-505(1)(k). A managed care plan is required to

unless there is a meaningful insurer-provider relationship, there is no true benefit to the consumer. A health insurance contract with stated benefits but no real means of accessing care is worthless.

This Court in *Metropolitan Life Ins. Co.*, 471 U.S. at 741, concluded that "nothing in § 514(b)(2)(A), or in the 'deemer clause' which modifies it, purports to distinguish between traditional and innovative insurance laws. The presumption is against preemption . . . " Like the mandated health benefit considered in *Metropolitan Life*, Kentucky's AWP statute is a state law that regulates the basic core of the insurance contract in an innovative manner and, therefore, is not preempted.

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court maintained that, under the common-sense view, a law must be specifically directed toward the insurance industry and not just have an impact on it in order to be a statute that regulates insureds. Kentucky's AWP statute satisfies this requirement. The statute only applies to those entities in the insurance industry under the regulatory authority of the Kentucky Department of Insurance.[6]

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ensure that an enrollee has an adequate choice of participating primary care providers. Ky. Rev. Stat. Ann. § 304.17A-520. A managed care plan is required to develop comprehensive quality assurance standards to ensure their members are receiving and have access to quality health care services. Ky. Rev. Stat. Ann. § 304.17A-545.

[6] Health Maintenance Organizations (required to get a certificate of authority by KRS 304.38-060); provider-sponsored integrated health delivery networks (required to get a certificate of filing by KRS 304.17A-300); and Multiple-Employee Welfare Agreements. (*See National Business Ass'n v. Morgan*, 770 F. Supp. 1169 (W.D. Ky. 1991). (ERISA does not exempt MEWAs from

For the reasons stated above, the Sixth Circuit's determination that Kentucky's AWP statute regulates insurance "as a matter of common sense" is proper and not in contradiction to this Court's findings in *UNUM Life*, *FMC*, *Metropolitan Life*, and *John Hancock*.

b. The Three McCarran-Ferguson Criteria.

Next, Petitioners maintain that the Sixth Circuit erred in concluding that Kentucky's AWP statute meets the three McCarran-Ferguson criteria. Specifically, Petitioners argue that the Sixth Circuit's decision contradicts this Court's precedents in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982). Respondent disagrees.

Royal Drug is a 1979 antitrust case wherein this Court ruled that pharmacy provider agreements are not the "business of insurance" within the meaning of the McCarran-Ferguson Act and, therefore, are not exempt from the antitrust laws. The pharmacy provider agreements at issue involved an insurance company's agreement with pharmacy providers to sell prescription drugs for $2.00 to the company's policyholders in exchange for reimbursement from the company for the cost of the drug. This Court held that these agreements were "merely arrangements for the purchase of goods and services" by the insurance company. *Royal Drug*, 440 U.S. at 214.

Kentucky insurance laws to the extent the laws do not conflict with ERISA).

Kentucky's AWP statute is distinguishable from the pharmacy agreements at issue in *Royal Drug*. Kentucky's AWP statute addresses much more than "arrangements for the purchase of goods and services." The Kentucky General Assembly passed the AWP statute as part of a sweeping healthcare reform measure. The General Assembly intended to make healthcare coverage more affordable and accessible to citizens of the Commonwealth and enacted these statutes as patient protection provisions to benefit the consumer. The Kentucky General Assembly did not enact the statute to benefit the insurance company or providers. Rather, Kentucky's AWP statute benefits the consumer by shifting part of the cost of healthcare from the insured to the insurer. This is done by allowing consumers greater access to providers and lessening the chances that the consumer will have to pay out-of-pocket to visit a provider of choice. The Kentucky General Assembly accomplished this task with an awareness of ERISA preemption. With preemption in mind, the AWP law was written so that it applied only to those entities engaged in the business of insurance.

The Fourth Circuit has determined that AWP statutes can indirectly affect "the insured's choice of provider and the consequent cost to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear." *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 504 (4th Cir. 1993), *cert. denied by Aetna Life Ins. Co. v. Stuart Circle Hosp. Corp.*, 510 U.S. 1003 (1993); *See also Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997) (distinguishing a prior AWP statue from *Royal Drug* and

concluding that the statute affects spreading of risk because it influences which costs are borne by the insurer and which are borne by the policyholder). Since Kentucky's AWP statute functions in the same manner as the AWP statute in *Stuart Circle* and the prior AWP statute in *Texas Pharmacy Association*, it is much more than "arrangements for purchase of goods and services."

Although one can argue that the agreements in *Royal Drug* did not concern the policyholder, one cannot argue the same for Kentucky's AWP statute. Access to qualified healthcare providers through insurers is of vital concern to consumers. The Department of Insurance, the entity charged with regulating health insurers in the Commonwealth of Kentucky, confronts this basic consumer issue as part of its daily regulatory function. Therefore, the Sixth Circuit correctly stated that "[u]nlike *Royal Drug*, policyholders in Kentucky will benefit under their policies by a new change in coverage, insofar as availability of providers is concerned." Petitioners' Appendix 62a-63a.

Royal Drug involved issues of antitrust law. As the court noted in *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.* 973 F. Supp 60, 72 (D. Mass. 1997), it is not clear that the holding in *Royal Drug* can "be translated to the ERISA preemption context at all."

Petitioners have maintained at both the district court level and the circuit court level that *Royal Drug* should be the standard applied in this case. That argument has been rejected every time. Again, on Petition for a Writ of Certiorari, Petitioners have failed to present any new arguments with regard to the applicability of *Royal Drug*.

Kentucky's AWP statute is also distinguishable from the statute at issue in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982). In *Pireno*, another antitrust case, this Court, relying on *Royal Drug*, found that peer review practices are not exempt from antitrust scrutiny as they are not part of the "business of insurance." The peer review committee advised insurance companies as to whether particular chiropractors' fees were necessary and reasonable.

Unlike the peer review committee in *Pireno*, the Department of Insurance's enforcement of Kentucky's AWP statute requires regulating the "business of insurance." Access to quality healthcare providers is the core of every health insurance contract and a concern of every consumer. A peer review committee's function simply does not have the same impact on an insurance contract or the consumer as does access to providers. A peer review committee only affects the relationship between the insurer and the provider. The committee determines the reasonableness of fees to be paid by the insurer to the provider and not whether the consumer may access that provider. Because a peer review committee's functions do not affect the insurance contract or the consumer, it is readily distinguishable from Kentucky's AWP statute.

As the Sixth Circuit stated, "it should be emphasized, in applying the McCarran-Ferguson factors, that 'the focus of McCarran-Ferguson is upon the relationship between the insurance company and its policyholders,' and state statutes aimed at regulating that relationship, 'directly or indirectly, are laws regulating the business of insurance.' " Petitioner's Appendix 64a, citing *United States Dep't of the Treasury v. Fabe*, 508 U.S. 491, 501 (1993).

Additionally, the Sixth Circuit correctly noted that "the three . . . factors are not required to be satisfied before a state law can be found to be a law regulating insurance." Petitioners' Appendix 68a.

i. Kentucky's AWP Statute Transfers Or Spreads Policyholders' Risk.

The Sixth Circuit Court of Appeals relied on the reasoning in *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 504 (4th Cir. 1993), *cert. denied by Aetna Life Ins. Co. v. Stuart Circle Hosp. Corp.*, 510 U.S. 1003 (1993) in determining that Kentucky's AWP statute was not preempted by ERISA. Petitioners' Appendix 60a-61a. *Stuart Circle* demonstrates how an AWP law can transfer or spread policyholder risk. *Stuart Circle* involved Aetna Health Management's challenge to Virginia's AWP statute. The Virginia AWP statute allows insurers to set up preferred provider organizations ("PPOs"), with terms and conditions that do not discriminate against providers willing to meet those terms and conditions. The Virginia Circuit Court found that:

> The Virginia statute affects the type and cost of treatment available to an insured. If a PPO unreasonably restricts the providers of treatment, even though they meet the insurer's standards, it denies an insured the choice of doctor or hospital that may best suit the insured's needs, unless the insured is willing and able to pay all or part of the cost of the doctor or hospital that is not preferred by the insurer. *Stuart Circle*, 995 F.2d at 503.

The Sixth Circuit correctly relied on the reasoning in *Stuart Circle*. Like Virginia's AWP statute, Kentucky's AWP statute provides insureds with a greater choice of healthcare providers. Without this choice, the insured would bear a greater share of the risk if that insured needed to use a non-participating provider. This is especially true, in rural Kentucky, where providers are scarce and a consumer's choice of health plans has historically been limited.

In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), the federal district court for the District of Massachusetts held that Massachusetts' Pharmacy Freedom of Choice-Any Willing Provider Act was not preempted by ERISA because it (1) did not "relate to" ERISA plans, and (2) constituted regulation of insurance protected from ERISA preemption by the savings clause. The court, in *American Drug*, also found the AWP statute "has the effect of transferring or spreading a policyholder's risk because, by enabling insureds to fill their prescriptions at additional pharmacies, it transfers some of the cost of treatment – which is the risk insured against – from the insured to the carrier." *Id.* at 71. Kentucky's AWP statute provides the same benefit to consumers.

Because Kentucky's statute allows for a greater choice of healthcare providers and, thus, limits the possibilities that the insured would have to pay an additional out-of-pocket expense to access a non-participating provider, it has the effect of spreading the risk.

ii. Kentucky's AWP Statute Meets The Criteria Of Affecting An Integral Part Of The Relationship Between The Insurer And The Insured.

The Sixth Circuit found the second McCarran-Ferguson factor "unquestionably present in this case." Petitioners' Appendix 65a. The Sixth Circuit's conclusion is correct.

Without a doubt, the ability to access quality healthcare is the most basic of all reasons for a consumer to enter into a health insurance contract. As stated previously, without access to healthcare providers, the benefits in a health insurance contract are meaningless. The court, in *American Drug*, concluded that Massachusetts' AWP statute was an integral part of the relationship between the insurer and the insured "because it affects the substantive terms of the policy by broadening the range of providers that an insured may choose." *American Drug Stores, Inc.*, 973 F. Supp. at 71. Similarly, the court in *Stuart Circle*, concluded that Virginia's AWP statute was an integral part of the relationship between the insurer and the insured, relying on the premise that "treatment and cost are important components of health insurance." *Stuart Circle*, 995 F.2d at 503.

By prohibiting insurers from discriminating against any provider willing to accept the terms for participation, Kentucky's AWP statute dictates a substantive term in the contract between the insurer and the policyholder. Consumers contract with insurers in order to have greater and more cost-efficient access to providers. Kentucky's AWP statute provides for greater access to providers and,

therefore, it affects an integral part of the relationship between the insured and the insurer.

iii. Kentucky's AWP Statute Meets The Test Of Limiting Regulation To Entities Within The Insurance Industry.

Kentucky's AWP statute also meets the test of being a law that is limited to entities within the insurance industry. Ky. Rev. Stat. Ann. § 304.17A-270 is found in the insurance code. The Department of Insurance is the state agency charged with the statutory duty of enforcing all provisions of the insurance code. The Department of Insurance can only enforce the provisions of the insurance code on entities that it regulates (e.g., risk-bearing entities, entities holding certificates of authority with the Department, entities registered with the Department to conduct business in the Commonwealth).[7] Ky. Rev. Stat. Ann. § 304.17A-270 is located in subtitle 17A of the insurance code. Subtitle 17A governs all health benefit plans issued by insurers in Kentucky. The Department only enforces the requirements of Kentucky's AWP statute on insurers that offer health benefit plans as defined in the insurance code.

For these reasons, Kentucky's AWP statute is limited to entities within the insurance industry.

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[7] This includes traditional insurance companies as well as Health Maintenance Organizations.

II. The Sixth Circuit's Decision Is Not In Conflict With Any Other Circuit.

Petitioners contend that Certiorari is warranted because the Sixth Circuit's decision "exacerbates an entrenched conflict in the circuits" as to whether AWP statutes are preempted by ERISA. Again, Respondent disagrees. The circuits have analyzed distinguishable AWP statutes and, therefore, it cannot be said that the circuits are divided on this issue.

a. The Eighth Circuit

Petitioners rely on *Prudential Ins. Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998) to argue that the circuits are divided on the issue of AWP statutes. However, reliance on this case is misplaced.

In *Prudential*, the Eighth Circuit examined the Arkansas Patient Protection Act[8] and determined that it did not meet the "common sense test" as a statute that regulated insurance. As the Sixth Circuit correctly pointed out, Arkansas' Act did not meet the common sense test "because, in part, its scope included 'employers and administrators of self-insured plans.' " Petitioners' Appendix 57a. Whereas, Kentucky's AWP statute is "directed towards and limited to health care 'insurers' " and, therefore, a statute that regulates insurance. Petitioners' Appendix 57a.

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[8] Ark. Code Ann. § 23-99-204(a)(3).

Unlike Arkansas' statute, Kentucky's statute is limited to entities that assume financial risk and, therefore, is specifically directed toward the insurance industry. *See Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1045 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999) (finding that a Washington law was "specifically directed" toward the insurance industry, "because it operates directly on HMOs and . . . entities . . . engaged in the business of health insurance.").

b. The Fifth Circuit

Next, Petitioners rely on *Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 105 F.3d 1035 (5th Cir. 1997) and *Cigna Healthplan of Louisiana, Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996) to argue that the circuits are divided on the issue of whether AWP statutes are preempted by ERISA. Petitioners' reliance on these cases is also misplaced.

In *Texas Pharmacy Ass'n*, the Fifth Circuit found a Texas statute relating to pharmacies preempted because it did not meet the third requirement in the McCarran-Ferguson test. Specifically, the Fifth Circuit found the Texas statute did "not fall within the savings clause because it is not limited to entities within the insurance industry." *Texas Pharmacy Ass'n*, 105 F.3d at 1038. The Texas statute applied to "health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other organizations that provide health care services." *Id.* The Fifth Circuit went on to state that if a self-insured employer, not subject to the Any Willing Provider

statute, "signed up with an HMO or PPO, those organizations would be subject to the statute, even if there is no insurance company involved." *Id.* at 1039.

Texas Pharmacy Ass'n is factually and legally distinguishable from the present case. First, as Petitioners concede, the Fifth Circuit did not analyze all of the factors relevant to the determination as to whether a statute "regulates insurance" for the purposes of the ERISA savings clause. Instead, the court merely analyzed the third requirement under the McCarran-Ferguson test to find the statute preempted. Thus, the court was requiring compliance with all the McCarran-Ferguson factors before it would find the statute saved from ERISA preemption. However, as the Sixth Circuit correctly noted "the three McCarran-Ferguson factors are not required to be satisfied before a state law can be found to be a law regulating insurance." Petitioners' Appendix 68a. Because the court in *Texas Pharmacy Ass'n* failed to apply the "common sense test" and analyze the statute under all three of the McCarran-Ferguson factors, the case is legally distinguishable from the present case.

Second, the court in *Texas Pharmacy Ass'n* found that the Texas statute applied to HMOs and PPOs acting as administrators of an employer's self-funded plan. *Texas Pharmacy*, 105 F.3d at 1039. Kentucky's statute does not function in such a manner. The Sixth Circuit correctly noted that "the Kentucky statute is directed toward and applies to only insurers and not to plan administrators." Petitioners' Appendix 59a. The Department of Insurance only regulates risk-bearing entities. "A plan administrator that does nothing more than administer the plan of a

self-insured employer is not engaged in 'the underwriting and spreading of risk.' " Petitioners' Appendix 59a, quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221 (1979).

For these reasons the Fifth Circuit's decision in *Texas Pharmacy Ass'n* is legally and factually distinguishable from the present case.

In *Cigna Healthplan of Louisiana*, the Fifth Circuit again analyzed a state statute by applying only the third factor of the McCarran-Ferguson test. In doing so, the Fifth Circuit concluded that Louisiana's statute is not limited to entities within the insurance industry and, therefore, preempted by ERISA. *Cigna Healthplan of Louisiana*, 82 F.3d at 650. The court found that "[e]ven though the statute lists insurers as one group covered by its terms, it also specifies, in a non-exclusive list, that it applies to 'self-funded organizations, Taft-Hartley trust, or employers who establish or participate in self-funded trusts or programs, . . . ' " *Id.*

Again, the Fifth Circuit's decision in *Cigna Healthplan of Louisiana* is legally and factually distinguishable from the present case. First, the Fifth Circuit did not fully analyze the statute when it failed to apply the "common sense test" and the three McCarran-Ferguson factors to the statute. Instead, the court found preemption after analyzing only the third factor of the McCarran-Ferguson test. Second, Louisiana's statute is distinguishable from Kentucky's AWP statute in that it does not meet the "common sense" definition of insurance because it attempts to regulate entities clearly outside the insurance industry (i.e., self-funded organizations and employers).

Kentucky's AWP statute is not as far reaching. Therefore, Petitioners reliance on *Cigna Healthplan of Louisiana* is erroneous.[9]

There is no conflict among the circuits. The circuits have reviewed different state statutes drafted by different state legislatures.[10] Petitioners would have this Court

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[9] Petitioners' reliance on *Corporate Health Ins., Inc. v. Texas Dept. of Ins.* 215 F.3d 526 (2000), *pet. for cert. pending sub nom. Montemayor v. Corporate Health Ins., Inc.* (No. 00-665) is also misplaced. In that case, the Fifth Circuit applied both parts of the test found in *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985) and *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999). It also correctly stated that "[t]he law need not satisfy each of these tests." *Corporate Health Ins.*, 215 F.3d at 537. The court, in *Corporate Health Ins.*, found a Texas law allowing managed care entities to be held vicariously liable for physician's negligence in delivering medical services preempted by ERISA because its "provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause." *Id.* at 539. However, again, the present case is distinguishable from the Petitioners' cited case. Kentucky's AWP statute does not conflict with any of ERISA's provisions or place additional requirements on ERISA plans. Finally, Respondent does not disagree with the Fifth Circuit's conclusion that ERISA's savings clause does not encompass statutes that apply to "employers and others not engaged in insurance practices." *Id.* at 538 & nn. 50-51. Respondent is not asking to extend the savings clause to cover such entities as Kentucky's AWP statute clearly only covers those entities "engaged in insurance practices."

[10] As pointed out by Petitioners in footnote 12, other courts have found AWP statutes preempted by ERISA. However, again, these statutes are distinguishable from Kentucky's AWP statute. The United States District Court for the Northern District of Alabama, in *Blue Cross and Blue Shield of Alabama v. Nielsen*, 917 F. Supp 1532, (N.D. Ala. 1996), *vacated as moot*, 142 F.3d 1375 (11th Cir. 1998) struck down two Alabama AWP

believe that a state legislature could not pass AWP legislation without it being preempted by ERISA no matter what language was used. That simply is not the case. Kentucky has successfully drafted and passed AWP legislation that, as both the district court and court of appeals found, is saved from ERISA preemption.

III. Petitioners' Attempt To Treat All State AWP Statutes The Same Must Fail.

Petitioners contend that Certiorari is warranted to resolve the issue of whether ERISA preempts AWP statutes. However, that is not the question before this Court. The Sixth Circuit, as did the Fourth, Fifth, and Eighth Circuits, considered materially different AWP statutes. Neither the Sixth Circuit, nor the other circuits, were asked to consider whether AWP statutes are "good for" the healthcare industry generally. Instead, each circuit was asked to analyze a particular state AWP statute and decide whether that AWP statute was preempted by ERISA. Each circuit decided this question by applying the test developed by this Court in *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985) and *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999).

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statutes that are distinguishable from Kentucky's AWP statute. Alabama's statutes "by their express terms [applied] to 'health insurers and **employee benefit plans**' and, therefore, did not meet the common-sense view of regulates insurance. *Id.* at 1539 (emphasis added). Kentucky's AWP statute only applies to insurers, as regulated by the Department, that offer health benefit plans in the Commonwealth, the terms and conditions of which are also regulated by the Department.

There is no issue of national importance. Petitioners simply want to broaden the scope of ERISA preemption because they do not like the general concept of AWP statutes. Petitioners are attempting to broaden the scope of ERISA preemption when this Court has recently narrowed ERISA preemption with regard to state regulation that was not contemplated to fall within a broad ERISA preemption umbrella. *See New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *DeBuono* v. *N.Y.S.A. – ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997); and *California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.*, 519 U.S. 316 (1997).

Certiorari is not warranted because this Court has already set forth a clear ERISA preemption test to be applied to state statutes. The test does not need to be modified or expanded. Regardless of Petitioners' "feelings" about AWP statutes, if a statute meets the two-part test, a court must find that the statute is not preempted. The Sixth Circuit correctly applied the test to Kentucky's AWP statute and correctly found that it is not preempted by ERISA.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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RESPONDENT'S APPENDIX A

KRS 304.17A-110 Requirement of compliance with specified conditions Regarding renewability and pre-existing conditions (repealed 7-1-99)

All health benefit plans issued or renewed on or after July 15, 1995, shall comply with the following provisions:

(1) All health benefit plans shall be renewable with respect to all eligible persons and dependents at the option of the policyholder or contract holder, except:

(a) For nonpayment or the required premiums by the policyholder or contract holder;

(b) For fraud or misrepresentation of the policyholder or contract holder;

(c) For intentional and abusive noncompliance with health benefit plan provisions;

(d) If the insurer ceases doing business in Kentucky and notice of the decision to cease to do business in Kentucky is provided to the department, and to either the policyholder or contract holder. Health benefit plans shall not be canceled by the insurer for one (1) year after the date of the notice required under this paragraph unless the business has been sold to another insurer. An insurer that ceases to do business in Kentucky shall not reenter Kentucky for a period of five (5) years from the date of the notice required under this paragraph.

(2) (a) Pre-existing conditions provision shall not exclude or limit coverage for a period beyond six (6) months, or twelve (12) months for health benefit plans issued after July 15, 1996, following the individual's effective date of coverage and may only relate to conditions which had,

during the six (6) months, or twelve (12) months for health benefit plans issued after July 15, 1996, immediately preceding the effective date of coverage, manifested themselves in a manner that would cause an originally prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received or as to a pregnancy existing on the effective date of coverage;

(b) In determining whether a pre-existing conditions provision applies to a person covered under a plan, all health benefit plans shall credit the time the person was covered under a previous health benefit plan provided by an insurer, including Medicaid and Medicare, if the previous coverage was continuous to a date not more than sixty (60) days prior to the effective date of the new coverage.

3. Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.

4. No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through the Kentucky Health Purchasing Alliance, any other health purchasing alliance, an association,

an affiliated group, the Kentucky state employee health insurance plan, or any other entity.